PRINTED: 05/13/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						,	(3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 150004			A. BUILDING 00 B. WING			COMPLETED 03/01/2016		
100007			<i>D.</i> ,,,	_	ADDRESS SYMVEST STREET, STREET	03/01/	2010	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE OHMAN AVE			
FRANCISCAN ST MARGARET HEALTH - HAMMOND					OND, IN 46320			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
S 0000	REGULATORT OR	LSC IDENTIFTING INFORMATION)		IAU			DATE	
Bldg. 00	This visit was	for a State hospital	S 00	000				
	complaint inve	•						
	1							
	Complaint # II	N00190431						
	Substantiated,	State deficiency						
	related to the a	allegations is cited.						
	Date of Survey: 03/01/2016							
	Facility Number: 005004							
	0.1.0.1/0.7/4.6							
QA: 04/05/16								
S 1118	410 IAC 15-1.5-8							
3 1110	PHYSICAL PLAN	Γ						
Bldg. 00	410 IAC 15-1.5-8 ((b)(2)						
	(b) The condition of	of the physical						
	plant and the over							
	environment shall	be developed and						
		n a manner that the						
	safety and well-be assured as follows							
	(2) No condition s	hall he created or						
	maintained which							
	hazard to patients,							
	employees.			110	Link coldwater to con-		0.610.010.01.6	
		ent review, observation	S 1	118	High coldwater temperatures a the room lavatories are impact		06/30/2016	
	and interview, th	e hospital failed to			and impact	<u>.</u>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		COMPLETED		
150004		150004	B. WING		03/01/2016		
				STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					OHMAN AVE		
FRANCISCAN ST MARGARET HEALTH - HAMMOND					OND, IN 46320		
				I IAIVIIVI			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	ensure cold water	er was provided to the			patient dialysis on several unit	s in	
	bathroom handw	ashing sinks used for			the A building as noted in the		
	portable dialysis	machines, which are			survey. The building was constructed in 1968 and we ha	ave	
	-	tain 37 degrees Celsius			determined that many of the	ave	
	•	l in 2 of 6 in-patient			shower diverter valves and		
		i iii 2 01 0 iii-patient			associated checkstop valves a	are	
	rooms	10) 41 . 741			leaking and allowing hot water		
		19) on the 7th floor and			bleed into the cold water pipes		
	•	cold water for 4 other			Since the plumbing is a series		
	•	(#7008, #7209, #7214			13 risers with each riser serving	-	
and #7216) on the 7		ne 7th floor.			rooms per floor, a leaking chec		
					stop valve on any of the 14 roo on a riser could affect any or a		
	Findings include	ed:			the other rooms on that riser.		
					a result and due to the age of		
1. Franciscan St. Margaret Health		Margaret Health			installation, the chosen solutio		
	Hammond 2015 Utility Management Plan stated, "The purpose of the Utility Systems Management Plan is to support a safe patient care and treatment				to replace all the check valves		
					and shower diverters for the		
					entire building, Coordination h		
					been challenging since the ho	t	
					and cold water supplies that		
	environment at Franciscan St Margaret				serve an entire riser must be soff for approximately 8 hours to		
	Health - Hammond by managing risks associated with the safe operation and functional reliability of utility systems."				repair all 14 rooms on that rise		
					Additionally, the parts needed	.	
					have been in short supply and	we	
					have consistently encountered		
	1	Management Plan was			back order situation. We		
	last reviewed Jan	nuary 2015.			currently have parts on hand to		
					do the next 3 risers and parts	are	
	2. Review of pa	tient's medical record			on order for the remainder.		
	(MR) #MR1 (Ro	oom #7219) indicated			Phase 1: 6 of 13 risers have		
	Acute Chart Sheet for hemodialysis dated 12/9/2015 had a start time of 0904 and an				been completed. (Rooms 1201-1207, 2201-2207,		
					3201-3207,		
). The comment noted			4201-4207,5201-5207,		
					6201-6207, 7201-7207,		
		arge Sheet stated, "			1210-1213, 2210-2213,		
		cool down water from			3210-3213,		
	^	room > R/O chlorine			4210-4213,5210-5213,		
tanks filled with hot water > temp on HD				6210-6213, 7210-7213) (total	77		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		00	COMPLETED	
1		150004	B. W	ING		03/01/	2016
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					OHMAN AVE		
FRANCISCAN ST MARGARET HEALTH - HAMMOND					OND, IN 46320		
	_			TIAIVIIVIC	JND, IN 40320		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Machine over 42	2 C (107.6 F)."			rooms) - Complete 5/10/2016	6	
					Phase2: 3 more risers (42		
	3. Review of pa	tient's medical record			rooms) will be completed by		
	_	7207) indicated Acute			5/30/2016 Phase3: The	a zi II	
	,	*			remaining 4 risers (49rooms) vibe completed by 6/30/2016	VIII	
		nemodialysis dated			Replacing all the valves and		
		art time of 0830 and an			diverters should prevent		
		5. The comment noted			reoccurrence of this problem.		
	on the Acute Ch	arge Sheet stated, "			Once the repairs are complete	d	
	Delays due to w	ater issues - 30+ minutes			and monitoring confirms that o		
	delays - sink not	draining (maint. called			water temps are being properl		
	(a) repaired) - hot water issues again, problem addressed by maint ran cold				maintained, the maintenance	staff	
					will respond promptly to any		
	water through adjoining sink, working				reports of water temperature problems. Monitoring will cons	ict	
	_				of checking the cold water tem		
	1	v. Cleaned up water that			in each room on a riser within	-	
	overflowed on floor."				week after the riser repairs are		
					complete and again 2 weeks la		
	4. Review of pa	tient's medical record			to insure repairs have solved t		
	#MR2 (Room #7207) indicated Acute				problem. If necessary, additio		
	,	nemodialysis dated			remedial repairs will be done u	ıntil	
		art time of 0955 and an			the riser is satisfactory for 2		
					successive samplings. The Director of Engineering and		
		The comment noted			Facilities Maintenance is charg	han	
		arge Sheet stated, "Hot			with monitoring and maintainir		
	water at bedside	, water alarm, system has			correction of the problem and	.9	
	to be set-up."				monitoring for any		
					reoccurrences. In the interim,	the	
	5. Review of a 1	nemorandum dated			clinical staffs have been appris	sed	
January 8, 2016 by staff member #5					of the situation, promptly repo	rt	
	(Maintenance Lead Tech) stated, " Dialysis workers were told by someone to				water temperature issues to		
					maintenance, and are assigning	-	
	1	•			patients needing dialysis to roon not having water temperature	J1115	
		But all that does is			problems as much as possible	1 .	
		ems we are running into			Frestonie de maon de possible	•	
	which is once th	e hot water from the					
	shower motor ge	ets into the cold the					
		2 rooms since they are					
whole ded tower 2 rooms since they are							

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 150004		A. BUILDING B. WING	<u>00</u>	COMPLETED 03/01/2016	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST MARGARET HEALTH - HAMMOND			5454 H	ADDRESS, CITY, STATE, ZIP CODE OHMAN AVE OND, IN 46320	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	_	hot in the cold line and ve to flush the lines."			
	on 3/1/2016. Ro sink was dischard 101 degrees Fahrt the toilet in room touch. Rooms # were observed dischard on the were turned on. was toured on the patient rooms we floor. The water inspected. The hathrough a water intemperature read ranged between 4 Fahrenheit. The would be set to 3 F). The machine when the water the degrees Celsius (4 7. At 2:20 PM of bathroom sink water discharged within a few second	was toured at 11:30 AM om #7216 bathroom ging water that exceeded renheit. The piping to a #7216 felt warm to the 7209, #7008, and #7214 ischarging hot water old and hot water knobs. The Dialysis Department to the 7th floor after random ere inspected on the 7th treatment room was not and cold water is fed regulator. The water ings exiting the regulator 42 and 58 degrees dialysis equipment 17 degrees Celsius (98.6 et was observed to alarm remperature exceeded 38 (100.4 F). In 3/1/2016, Room #4216 as tested for cold water. It was activated and the lacold at first; however, above 100 degrees			
	tested because th	m #4216 (4th floor) was e water flow through s room #7216 (7th floor).			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 150004		A. BUILDING B. WING	<u>00</u>	COMPLETED 03/01/2016				
NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST MARGARET HEALTH - HAMMOND			STREET ADDRESS, CITY, STATE, ZIP CODE 5454 HOHMAN AVE HAMMOND, IN 46320					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	member #5 indicare tied together pipe chase has a assembly that disand the cold water However, the expipe chase are not of assembly are assembly is not fit the hot water is towater lines. The causing the cold water when cold water when cold water when cold something the cold allysis machine have temperature increase the cold 37 degrees Celsi temperature control safety of the patiblood of bad condialysis machine Celsius (100.4 Finto bypass and stemperature decreachine will starpatient's blood. Water dispensing	stributes the hot water er when activated. isting assemblies in the ear 40 years old and parts seized up. When the functioning as designed, pleeding into the cold se malfunctions are water discharging hot water was activated. In 3/1/2016, staff lysis Senior Registered I the process of the se booster heaters that water temperature up to						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150004	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/01/2016	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST MARGARET HEALTH - HAMMOND			5454 H	ADDRESS, CITY, STATE, ZIP CODE OHMAN AVE OND, IN 46320		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
	machines going	to the patient's rooms.				

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